



Hospital Fiscal Report

State Form 49520 (R2 /7-02)

(Form approved by State Board of Accounts, 2000)

I. Identification of Organization

Hospital Name: KINDRED HOSPITAL NORTHWEST INDIANA

City of Hospital: Hammond

Year Begin: 12/01/2012 (mm/dd/yyyy format)

Year End: 12/31/2012 (mm/dd/yyyy format)

Medicare Provider Number: 152012

Statement One: Summary of Revenue and Expenses

1. Gross Patient Service Revenue

Inpatient Patient Service Revenue	\$72140356
Outpatient Patient Service Revenue	\$0
Total Gross Patient Service Revenue	\$72140356

2. Deductions From Revenue

Contractual Allowance	\$45193618
Other Deductions	\$0
Total Deductions	\$45193618

3. Total Operating Revenue

Net Patient Service Revenue	\$26946738
Other Operating Revenue	\$0
Total Operating Revenue	\$26946738

4. Operating Expenses

Salaries and Wages	\$8384527	Employee Benefits	\$1327535
Depreciation and Amortization	\$345863	Interest Expense	\$0
Bad Debt	\$452358	Other Expenses	\$10194673
Total Operating Expenses	\$20704956		

5. Net Revenue and Expenses

Excess Revenue over Expenses	\$3932178	Total Assets	\$5300645.25
Net Non-operating Gains over Loss	\$0	Total Liabilities	\$1940420.80
Total Net Gains	\$3932178		

Statement Two: Contractual Allowance

Revenue Source	Gross Patient Revenue	Contractual Allowance	Net Patient Service Allowance
----------------	-----------------------	-----------------------	-------------------------------

Medicare	\$59817296	\$38880829	\$20936467
Medicaid	\$345865	\$284664	\$61201
Other Government	\$0	\$0	\$0
Other State	\$0	\$0	\$0
Other Payers	\$11977196	\$6028126	\$5949070
Total	\$72140357	\$45193619	\$26946738

Statement Three: Donations Statement

	Estimated Incoming Revenue	Estimated Outgoing Expenses	Net Dollar Gain or Loss
Donations	\$0	\$0	\$0

Statement Four: Research Statement

	Estimated Incoming Revenue	Estimated Outgoing Expenses	Net Dollar Gain or Loss
Research	\$0	\$0	\$0

Statement Five: Education Statement

Education of	Estimated Incoming Revenue	Estimated Outgoing Expenses	Net Dollar Gain or Loss
Medical Professionals	\$0	\$0	\$0
Hospital Patients	\$0	\$0	\$0
Community Education	\$0	\$0	\$0

Number of Medical Professionals Trained	0
Number of Hospital Patients Educated	0
Number of Citizens Exposed to Health Education Messages	0

Statement Six: Charity Statement

Hospital Charity Charges	\$0
--------------------------	-----

	Payments from Clients	Less Costs to Hospital	Unreimbursed Costs to Hospital
Charity Care	\$0	\$0	
HCI Payments	\$0		
Subtotal	\$0	\$0	\$0
Medicaid Shortfalls	\$0	\$0	
Subtotal	\$0	\$0	\$0
DSH Payments	\$0		
Subtotal	\$0	\$0	\$0
Medicare Shortfalls	\$0	\$0	
Other Government Programs	\$0	\$0	
Total	\$0	\$0	\$0

Statement Seven: Subsidized Health Services for the Community

	Estimated Incoming Revenue	Estimated Outgoing Expenses	Net Dollar Gain or Loss
Community Programs	\$0	\$0	\$0
Community Assessment	\$0	\$0	\$0
Provision of Taxes	\$0	\$0	\$0
Other Allocations	\$0	\$0	\$0